MDR: M4-02-2576-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service, 2-5-01 though 3-16-01.

   b. The request was received on 2-6-02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. Initial TWCC 60
      1. EOBs
      2. HCFA 1500s
   b. There is no response to the request for additional documentation found in the file.
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome

2. Respondent, Exhibit II:
   Based on Commission Rule 133.307 (g) (4), the Division notified the Requestor with a copy to the insurance carrier Austin Representative of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 6-11-02. There is no Carrier initial or 14 day response to this medical fee dispute noted in the file.

III. PARTIES' POSITIONS

1. Requestor: No position statement.

2. Respondent: No position statement.

IV. FINDINGS

1. Based on Commission Rule 133.307(d)(1&2), the only (DOS) eligible for review are 2-6-01 through 3-16-01. Date of service 2-5-01 was not filed within the one year time frame and therefore, not within the jurisdiction of the Commission.

2. The amount billed per the TWCC-60 is $34,125.00. The amount reimbursed $23,300.20.

3. The amount in dispute per the TWCC-60 is $10,824.80.

4. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

V. RATIONALE

Medical Review Division's rationale:

The Requestor has submitted a HCFA 1500 which reflects billing for CPT Code 97799 CP AP, Chronic Pain Program for dates of service 2-6-01 through 3-16-01. The Provider has forwarded a copy of the EOBs relevant to the disputed dates of service.

However, when determining whether or not reimbursement is warranted, the Medical Review Division must first determine that the services were rendered as billed. After review of the dispute file, no documentation was noted to support the services billed. Therefore, no additional reimbursement is recommended.

The above Findings and Decision are hereby issued this 22nd day of August 2002.

Lesa Lenart, RN
Medical Dispute Resolution Officer
Medical Review Division

LL/ll

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.